DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

2. TRANSMITTAL NUMBER: 04-26 | 2. STATE: Maryland

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)
Medicaid

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
April 1, 2004

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:

7. FEDERAL BUDGET IMPACT:
a. FFY 2004 $ 3M
b. FFY 2005 $ 4M

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19D, Page 1
Attachment 4.19D, Page 2
Attachment 4.19D, Page 7B
Attachment 4.19D, Page 11

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Attachment 4.19D, Page 1 (04-10)
Attachment 4.19D, Page 2 (04-10)
Attachment 4.19D, Page 7-B (04-10)
Attachment 4.19D, Page 11 (04-10)

10. SUBJECT OF AMENDMENT:
The nature of this change in the State Plan is one of cost containment. Reimbursement parameters have been cycled down in order to achieve $4M in savings (State and Federal) during the balance of State Fiscal Year 2004.

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Susan J. Tucker, Executive Director
Office of Health Services

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Nelson Sabatini

13. TYPED NAME:
Nelson J. Sabatini

14. TITLE:
Secretary, Department of Health and Mental Hygiene

15. DATE SUBMITTED:
April 20, 2004

16. RETURN TO:
Susan J. Tucker, Executive Director
DHMH - OHS
201 W. Preston St., Rm 127
Baltimore, MD 21201

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: APR 20 2004

18. DATE APPROVED: JUN 21 2004

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: APR - 1 2004

20. SIGNATURE OF REGIONAL OFFICIAL:
Brenda M. Smith

21. TYPED NAME: Charlene Brown

22. TITLE: Deputy Director, CMSO

23. REMARKS:

4.19(d) Nursing facility payment rates are based on Maryland regulations COMAR 10.09.10 in order to account for the cost of services required to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident eligible for Medicaid benefits. Payment rates for nursing facilities are the sum of per diem reimbursement calculations in 4 cost centers: administrative/routine, other patient care, capital, and nursing service; and payment for therapy services. Payments in the aggregate may not exceed Medicare upper limits as specified at 42 CFR 447.272.

In accordance with the Omnibus Budget Reconciliation Act of 1987, nursing facility payment rates, effective October 1, 1990, take into account the costs of nursing facilities' compliance with the requirements of Sections 1919(b) (other than paragraph (3)(F)), 1919(c), and 1919(d) of the Social Security Act. Appended to this attachment is a description of the provisions, which represent changes from Maryland's pre-existing requirements.

Nursing facilities that are owned and operated by the State are not paid in accordance with the provisions described below, but are reimbursed reasonable costs based upon Medicare principles of reasonable cost as described at 42 CFR 413. Aggregate payments for these facilities may not exceed Medicare upper payments limits as specified at 42 CFR 447.272.

Administrative/Routine Costs

The Administrative/Routine cost center includes the following expenses: administrative, medical records, nurse aide registry fees, training, dietary, laundry, housekeeping, operation and maintenance, and capitalized organization and start-up costs. There are 3 reimbursement groups in this cost center based on geographic location, as specified under COMAR 10.09.10.24A (which is appended to this attachment).

Providers per diem costs are calculated at the actual occupancy of the nursing facility beds or at the Statewide average occupancy of nursing facility beds plus 1.5 percent, whichever is higher, for the calculation of ceilings, current interim costs and final costs.

Although an interim Administrative/Routine rate is calculated for each provider, based on indexed cost report data, the final per diem reimbursement rate, after cost settlement, is the sum of:

(1) The provider's allowable per diem costs for covered services according to the principles of reasonable cost reimbursement established under 42 CFR Part 413, subject to the ceiling calculated for the provider's reimbursement class, and

(2) For those providers with costs below the ceiling, an efficiency allowance equal to 40 percent of the difference between the ceiling and the provider's costs, subject to a cap of 10 percent of the ceiling.

The interim per diem rates for the Administrative/Routine cost center is the sum of :

(1) The provider's indexed per diem costs subject to the ceiling calculated for the provider's reimbursement group, and

(2) For those providers with projected costs below the ceiling, 90 percent of the efficiency allowance as calculated above.

Ceilings are calculated for each of the 3 reimbursement groups. Each year all providers enrolled in the Program are required to submit a cost report within 3 months of their fiscal year end. Current administrative and routine costs are adjusted, using indices established under COMAR 10.09.10.20 (which is appended to this attachment), by indexing them from the mid-point of the provider's fiscal year to the midpoint of the State's fiscal year for which rates are being established. Indexed per diem costs are calculated by dividing indexed expenses by total days of care. The indexed per diem costs for Maryland providers are then weighted by their associated paid Medical Assistance days and the median per diem costs for each reimbursement group is determined. The maximum per diem rate is 112 percent of the median cost in each group. The ceilings are applied, as described above, to determine each provider's interim per diem payment.

Other Patient Care Costs

The Other Patient Care cost center includes expenses for providing: a medical director, pharmacy, recreational activities, patient care consultant services, raw food, social services and religious services. There are 3 reimbursement groups in this cost center, based on geographic location, as specified under COMAR 10.09.10.24 (which is appended to this attachment). Both the final per diem and interim per diem rates for the Other Patient Care cost center are determined as are those in the Administrative/Routine cost center. (Indices for Other Patient Care are established under COMAR 10.09.10.21 which is appended to this attachment.) Ceiling calculations are also identical except that the maximum per diem rate is 118 percent of the median projected per diem cost in each group. For providers with costs below the ceiling, the efficiency allowance is 25 percent of the difference between the ceiling and the provider's costs, subject to a cap of 5 percent of the ceiling.

When an improvement in ADL classification is achieved by a facility for a resident who has been at the prior (higher) ADL classification for a minimum of 2 consecutive months, reimbursement for that resident will continue at the prior (higher) ADL classification until discharge, transfer, a return to the prior (higher) ADL classification, or for 2 subsequent months, whichever is less, in order to provide a transitional staffing adjustment to the facility in the amount of the difference between the reimbursement associated with the prior (higher) and the current (lower) ADL classifications.

The interim nursing service payment is subject to cost settlement. Providers with nursing costs less than reimbursement at standard per diem rates are allowed to keep as profit a maximum of 4.0 percent of nursing reimbursement at standard rates. The sum of reimbursement and profit cannot exceed reimbursement at standard rates.

Nursing reimbursement in excess of costs and allowable profit is subject to recovery. Providers that are projected to spend less than their full reimbursement in this cost center, based on nursing costs reported in the most recent desk-reviewed cost report, indexed to the mid-point of the rate setting year, will have their interim rates reduced by 95 percent of the amount projected to be recovered. The balance of the recovery will occur at final cost settlement.

The above-mentioned percentage adjustments for communicable disease care and central intravenous line are not subject to cost settlement.

A provider that renders care to Maryland Medicaid recipients of less than 1,000 days of care during the provider's fiscal year may choose to not be subject to cost reporting or field verification requirements and choose to accept as payment the projected Medicaid statewide average payment for each day of care. Any provider choosing this option is exempt from the subsequent nursing cost center wage survey.

Intermediate Care Facilities for the Mentally Retarded are a separate class and such facilities are reimbursed reasonable costs. The determination of reasonable costs is based on Medicare principles of reasonable cost as described at 42 CFR 413. An average cost per day for provider-based physician services is developed and paid in accordance with retrospective cost reimbursement principles. Payments in the aggregate may not exceed Medicare upper limits as specified at 42 CFR 447.272.

(5) The allowance for movable equipment shall be:

(a) Established at $4,500 per licensed bed effective December 31, 1999;

(b) Indexed forward as determined from §E of this regulation; and

(c) Added to the appraised value determined from §G(1), (2), (4), and (5) of this regulation.

(6) The allowance for movable equipment will exclude all items which:

(a) Are regularly replenished or stocked, consumed in their use or have a one-time use, or useful for a lifetime of less than 2 years; or

(b) Have an historical or aggregate historical cost of less than $500.

(7) The amount of the allowable mortgage debt as of the midpoint of the fiscal year shall be subtracted from the allowable appraised value from §G(2) of this regulation in order to establish the value of the net capital.

(8) The debt information to be used in §G(7) of this regulation shall be supplied to the Department or its designee by each facility in the form of a monthly amortization schedule within 60 days of the establishment of the debt.

(9) The value of net capital from §G(7) of this regulation shall be multiplied by 0.0757 in order to generate the net capital value rental.